Bureau of Health Care Quality and Compliance

AND DIANIOE CODDECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	NVS5737AGZ			B. WING			C 02/23/2011	
				RESS, CITY, STA	ATE, ZIP CODE	<u> </u>	5/2011	
I WILLOW CDEEK MEMODY CADE CAN MADTIN I			NIER BLVD S, NV 89113					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE COMPL O THE APPROPRIATE DATE		
Y 000	Initial Comments			Y 000				
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 2/23/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 62 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 24. Ten resident files were reviewed and ten employee files were reviewed. The facility received a grade of B. The following deficiencies were identified:		Y 255					
		ary permits from the Buservices of the Division.						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING		С			
NVS5737AGZ				B. WING		02/23/2011			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
I WILLOW CREEK MEMORY CARE SAN MARTIN I				GNIER BLVD GAS, NV 89113					
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Y 255	Continued From page 1			Y 255					
	This Regulation is not met as evidenced by: Based on observation, interview and record review on 2/23/11, the facility failed to ensure the kitchen complied with the standards of NAC 446.								
	Findings include:								
	Cleaning and Sanitation Issues:								
	a. There were opened, undated containers of milk and heavy cream in the reach-in refrigerator.								
	b. The wash temperature on the dishmachine was 130 degrees F, rather than 150 degrees F.								
	c. The cutting board and interior of the ice machine were soiled.d. The wall and ceiling around the vents were soiled on the cook's line.								
	Severity 1: Scope: 3	3							
Y 393 SS=E	449.226(4)(a)-(c) Saf	ety Requirements		Y 393					
	residents: (a) Each resident much bedroom and bathrood equipped with, an aumonitored by a member (b) An auditory system.	st be provided with, or to om of each resident mu ditory system that is over of the staff of the fac m must be available for ich resident of the facilit	st be cility. use						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING B. WING			С	
		NVS5737AGZ	_			02	/23/2011
WILLOW CREEK MEMORY CARE SAN MARTIN			DRESS, CITY, STATE, ZIP CODE NIER BLVD S, NV 89113				
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Y 393	January 14, 1997, so assistance can alert facility of that fact fro (c) A bathroom that i of the facility must be	d its initial license on conthat a resident needing a member of the staff of the toilet and the short located in a commone equipped with an aucored by a member of the	ng of the lower. n area ditory	Y 393			
	Based on observation failed to ensure a meto the auditory system	·	ty onded ade in				
Y 830 SS=D	submit to the Division permission to admit of prohibited from being facility or remaining a	r of a residential facility n a written request for or retain a resident who g admitted to a resident as a resident of the fac 0.271 to 449.2734, inc	o is itial ility	Y 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/23/2011			
	NVS5737AG			B. WING					
				RESS, CITY, STA	TE, ZIP CODE				
				NIER BLVD AS, NV 89113					
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Y 830	This Regulation is not met as evidenced by: Based on observation and interview on 2/23/11, the administrator failed to request a waiver to retain a bedfast resident (Resident #1). Severity: 2 Scope: 1			Y 830					
Y 997 SS=F	Y 997 449.2756(1)(f)(3) Alzheimer's Facility-Yard			Y 997					
	NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (3) Is fenced.								
	or yard to an unsecu	n the secured, fenced a red open area or yard n or gates must be readily bers of the staff of the f	nust /						
	Based on observation failed to ensure 2 of 2	ot met as evidenced by n on 2/23/11, the facility 2 gates located in the he front of the facility w	′						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		NV05707407		A. BUILDING B. WING		C			
NAME OF P	ROVIDER OR SUPPLIER	NVS5737AGZ	STREET ADDR	02/23/2011 EET ADDRESS, CITY, STATE, ZIP CODE					
WILLOW CREEK MEMORY CARE SAN MARTIN				7230 GAGNIER BLVD LAS VEGAS, NV 89113					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
Y 997	Continued From page	e 4		Y 997					
		Scope: 3							